FULL ANONYMISED REPORT OF THE INDEPENDENT INQUIRY REFERENCE 1999/195

COMMISSIONED BY
CALDERDALE AND KIRKLEES HEALTH AUTHORITY

PREFACE

A panel consisting of the persons listed below was established by Calderdale and Kirklees Health Authority in August 2001 to undertake an inquiry into the care and treatment of DG.

Mrs Anne Galbraith LL.B Chairman	Formerly Senior Lecturer in Law in the University of Northumbria and Chair, Prescription Pricing Authority
Mrs Anne Butterworth	Retired Senior Health Service Manager and Registered Mental Health Nurse
Dr DG Armstrong	Consultant Psychiatrist
Mrs Margaret Errington	Approved Social Worker and Community Mental Health Team Manager.

We now present our report, having had regard to the terms of reference set down for us by the Authority, and having adopted the procedure set out in Appendix A.

Anne Galbraith	DG Armstrong
Margaret Errington	Anne Butterworth

Date:

CHAPTER ONE

BACKGROUND TO THE INQUIRY

Introduction

1.1 This inquiry was established by the Calderdale and Kirklees Health Authority in pursuance of the guidance contained in the NHS Management Executive document HSG (94)27, which requires such an inquiry to be held where there has been a homicide committed by a person who has been receiving mental health services. The guidance suggests that where a violent incident occurs, it is important to learn lessons for the future. That is the purpose of this inquiry.

1.2 The process of setting up the inquiry team was commenced after the inquest had taken place into the deaths of DG, and his son, MG. At those inquests in May 2000, it was found that MG had been unlawfully killed as a result of ligature strangulation, which had been carried out by his father. The Coroner also recorded a finding that DG had killed himself by hanging, after taking his son's life.

1.3 Once a panel had been established, the members met to determine the method of working, and to decide which records, documents and publications it required. Work was put in hand to obtain the necessary consents for the release of records and documents, and to establish who should be approached to meet the panel at oral hearings. A programme of dates was established, in order to minimise delays.

1.4 The approach adopted by the panel was based on experience of earlier panels. The panel was also mindful of the judgement in Crampton and others v Secretary of State for Health (the Allitt case) which set out some important principles to be borne in mind in such proceedings. There is a note of the procedure adopted by the panel at Appendix A.

1.5 The report of the panel is the result of the combined views and opinions of all the panel members.

Terms of reference for the Inquiry

1.6 The terms of reference established by Calderdale and Kirklees Health Authority in consultation with Calderdale Social Services Department, are set out in Appendix B.

Meetings with relatives

1.7 An early opportunity was taken for the Chairman of the panel to meet with the widow of DG, and her son by a former marriage, to explain the process involved in the inquiry and the scope of the terms of reference, and to answer any questions they may have about the process.

1.8 At that stage, from the limited amount of information available to the panel, it was not clear that DG had always maintained strong and regular contact with the children of his first marriage. They contacted the Health Authority after the announcement of the inquiry was made, and the Chairman of the Panel then sought to meet with representatives of the family, to afford them a similar opportunity to learn about the scope and processes and to put their questions.

Oral hearings

1.9 From the records available to the panel, and from discussions with relatives of DG, a preliminary judgement was made by the panel about those they wished to meet at oral hearings. The letter of invitation which was sent is reproduced as Appendix C.

1.10 Some of those attending the oral hearings were accompanied by a colleague or friend or relative. In both the health and social services, it was clear that a number of those interviewed had changed roles since the time of these incidents, and had been affected by reconfigurations of services.

1.11 All those attending were given information by the Chairman with regard to the format of the interview, the process of recording for the purposes of producing transcripts, the opportunity afforded to correct the draft transcript, the order in which the panel would ask questions, how the draft report would be prepared, and the opportunity which would be afforded for further comment and response at draft stage to anyone who may be the subject of criticism in the report.

1.12 During the oral hearings, it became clear to the panel that there were further records held by Social Services which could prove valuable to the work of the panel. Steps were taken to obtain these records, and in consequence, further oral hearings were held.

The Report

1.13 At the close of the oral hearings, members of the panel took time to reflect on what they had heard and read, and to formulate their thinking about the key issues which had emerged during the hearings and from the written information they had gathered. A working draft of the document was then prepared by the Chairman with appropriate contributions from members of the panel. This working draft formed the basis for a number of further drafting meetings, when the draft was revised in the light of the discussions.

1.14 Those sections of the report which might be regarded as critical were identified by the panel, and these were then sent to those concerned, to give them an opportunity to comment further, or to submit any further observations or material which they considered to be relevant.

1.15 These responses and further observations were then considered by the panel, and further re-drafting was undertaken where appropriate.

Acknowledgements

1.16 The panel wishes to record its thanks to Anne and Peter Johnson, who have provided the administrative support for the panel, and to Janice Doherty, who has acted as the link person in the Health Authority, and subsequently at the Primary Care Trust.

CHAPTER TWO

THE INCIDENT AND THE OUTCOME

2.1 DG, aged 55, had married for a second time in 1986. He and his second wife had one son, MG, born in 1986. MG was diagnosed as suffering from agenesis of corpus colosum, pulmonary stenosis and epilepsy.

2.2 MG is described as a happy and friendly child. He had learning difficulties, and required considerable support from his parents, particularly his mother. The family were devoted to MG, and their family life and outings would revolve around those things which MG enjoyed.

2.3 DG was an engineer, in a business which he had established with colleagues. He had suffered for many years with problems with his back, and had first been operated on for a prolapsed disc in 1966. His back problems became worse, and were an overriding feature of his health from 1995. He had also had an early spell of depression, in 1976, when he had a very brief admission to Halifax General Hospital. He was diagnosed as having reactive depression, and appears to have been followed up once in out-patient clinic, but did not attend for a second appointment.

2.4 DG suffered another more significant bout of mental illness in 1998, when he was admitted to Northowram hospital for a month. He was diagnosed as suffering from "recurrent depressive disorder, current episode severe with psychotic symptoms". He appeared to make a good recovery from this illness, but during the spring of 1999, he appears to have become depressed again.

2.5 A recurring feature of his suffering with his back was his anxiety about looking after MG as he and his wife got older. There were times when his back pain was so severe that he did speak of suicide. There were also occasions when he spoke of taking MG with him.

2.6 In July 1999, over a weekend when DG’s wife's son by her first marriage was away from home, DG killed his son MG by strangling him. He also attacked his wife and inflicted very severe head injuries on her. He then hanged himself.

CHAPTER THREE

ISSUES AND CONCERNS ARISING FROM THE CARE OF DG

Introduction

3.1 The panel have approached the care of DG by examining each aspect of the service separately. Issues with regard to the organisation of services and effective collaboration between services are considered in Chapter Five.

Care from the General Practitioners.

3.2 The panel has looked in detail at the care provided for DG after he transferred to the Keighley Road Surgery in 1995. There are a number of doctors in the practice, and over the period during which DG was registered as a patient, he was seen by Dr C, Dr D, Dr K, Dr Z, Dr I and at least one locum doctor.

3.3 The main entries in DG's GP notes break down into visits or calls related to his back pain, or concerning his depression, or concerning a mixture of his back problems and depression.

3.4 Overall, the detail within the notes is good. There does not appear to have been any problem with regard to obtaining timely appointments with a GP. When appropriate, the GPs showed themselves willing to make home visits.

3.5 There is evidence that the GPs were well acquainted with the mental health services in their area and had good lines of contact and communication with them. An early appropriate referral was made to the Quick Response Team in April 1996, which did not result in Community Psychiatric Nurse involvement with DG at that time, but it did mean that DG himself had been given the phone number of the team if he should feel the need to contact them.

3.6 When a later referral was made in June 1998, by Dr C to Dr S, the consultant psychiatrist, it is not clear whether any reference was made to this earlier referral. **The panel accepts** that the circumstances surrounding the two referrals were rather different, the earlier one concentrating on issues of DG's back pain and the thoughts this caused about ending his life, whereas the later referral was as a consequence of DG's paranoid thoughts about his wife having an affair. However, in the view of the panel, it may have been useful to Dr S, the consultant psychiatrist to have known about this earlier episode, particularly in view of the fact that he had elicited that DG's brother had committed suicide. **The panel believes** that it would also have been helpful to refer to earlier documented episodes in the GP notes of anxiety, depression, panic attacks and weepiness.

3.7 Where doctors from the practice were referring DG for treatment for his back, they were usually careful to make reference to his mental state. **The panel considers** that these letters were effective evidence that the GPs were constantly mindful of DG's state of mind, even where no particular note of his mental state has been recorded. **The panel has also taken account** of the fact that both Dr I and Dr D had undertaken training in psychiatry.

3.8 When DG was manifesting paranoid feelings about his wife, Dr C was able to organise a domiciliary visit very quickly by Dr S, the consultant psychiatrist. This was one of two occasions when such domiciliary visits were arranged. **The panel considers** that on each occasion, a domiciliary visit was the appropriate response.

3.9 One feature of DG's care which was of considerable concern to members of his family was the number of different drugs he was taking. These were referred to as a "cocktail" by several members of his family, who recounted how he carried them round in a carrier bag. It was also a feature which was noted by his CPN, who was sufficiently concerned about the matter to contact Dr I to identify exactly what DG should be taking in respect of his back pain.

3.10 Insofar as drugs for his depression are concerned, **the panel considers** that the GPs acted appropriately in maintaining the prescribing regime which had been established by Dr S, the consultant psychiatrist.

3.11 Insofar as drugs for his back pain are concerned, these were changed at intervals, to try to accommodate the varying symptoms and degree of pain being experienced. In combination, **the panel accepts** that DG was probably taking a substantial number of pills each day. **The panel considers** that the prescribing regime of the GPs was adequate, but wish to point out that the computer print out from the GPs is somewhat confusing, and that on two occasions, DG appears to have been given duplicate prescriptions on the same date.

3.12 In assessing the contribution made by the GPs in the practice to the care of DG, **the panel considers** that overall, the doctors were

compassionate and knowledgeable about his problems. **The panel also recognises** that the GPs may not have had a detailed knowledge of the family dynamics, as their home visits were infrequent, and although MG was a patient of the practice, much of his care was given by specialist aspects of the paediatric service. **The panel notes** that the practice is still caring for DG's wife.

In patient care at Northowram Hospital

3.13 The panel is aware that the service which was previously located on Sunderland Ward at Northowram Hospital has now been re-located to Calderdale Royal. However, some of the comments and observations may have significant relevance to the organisation of the service in its new location.

3.14 DG was admitted to Northowram Hospital following a visit by his CPN, E, who was sufficiently concerned on an urgent visit to DG that he contacted Dr S, the consultant psychiatrist, informed him of the situation, and established that it was alright to admit him. He also telephoned Dr C and obtained her approval for an informal admission. **The panel considers** that this admission was a good example of the close working between the CPN, Dr S, the consultant psychiatrist and the GP practice.

3.15 Once DG had arrived at the hospital, there is an adequate admission history, except that it lacks detail about DG's suicidal ideation. The history is indistinctly signed, but was probably taken by the clinical assistant. . There is also a detailed assessment, including an assessment of risk, completed by one of the nurses, who also wrote a useful entry in the daily nursing report. **The panel believes** that these notes and records, in particular those of the nurse, contain some significant information, particularly in relation to possible risk to MG, the importance of which appeared not to be taken sufficiently into account by the team caring for DG over the period of his in-patient stay.

3.16 When making the comments above, the panel has taken into account the fact that the joint assessment of the overall risk at the time of admission was low. The panel considered this assessment to be at odds with the information which was available to those making the assessment. Indeed it appears so contradictory that it is difficult to reconcile it with DG's situation. This risk assessment is also signed by a doctor**. The panel is concerned** that such an assessment may have sent out inappropriate messages to staff on the ward.

3.17 Thereafter, the notes made during DG's stay, particularly the nursing notes, **are regarded by the panel** as being of particularly poor quality, in terms of the level and quantity of information they contain, and they are not an effective instrument for the communication of vital messages about risk, leave, discharge, and child protection issues.

Dr S, the consultant psychiatrist's notes are adequate, but they do not focus sufficiently on issues of wider concern, such as family dynamics, social situation or child care. Some of the notes suffer from being made by persons with illegible signatures.

3.18 On one occasion, on 25 August 1998, there is a failure to make a note of significant information which was passed to nursing staff, by E, the CPN, in relation to an incident which had taken place in the hospital car park. **The panel believes** that E did communicate this information, and it is significant that there is a daily observation sheet in the notes, showing that from 13.50 to 20.00 hours that day, level 2 observations were carried out on DG. Nothing in the notes indicates why these observations were instituted, but they may have been a response to the information from the CPN. **The panel members consider** it was important information, and they regard the failure to record it as an important omission from the notes. In consequence, this information did not inform subsequent opportunities to assess risk. Furthermore, there is no indication in the notes that the temporary period of higher level of observations was ever discussed again.

3.19 Once information was placed on the record in the notes, **the panel was concerned** to see that plans recorded there were not adhered to. For example, there is a clear note that Ovenden's Child team should be informed if DG was going home for any reason. The panel reads this note as including both periods of leave and discharge. So far as can be ascertained from the evidence which the panel has seen and heard, this plan was not carried out. DG went out on leave on three occasions before his discharge, and there is no record of the Child team being informed. On the basis of the evidence that the panel has heard and read**, the panel believes** that Ovenden's Child team was never informed of DG's leave.

3.20 It is clear from the documentation that Sunderland Ward operated a key worker system. Q was named as the key worker for DG**. The panel accepts** that there are constraints on the key worker system, whether caused by shift patterns, holidays or the other demands of a busy ward. However, the system appeared to panel members to make little meaningful impact on DG's care. Of the three recorded evaluation meetings in the notes, one was undertaken by another nurse, and one simply records that the meeting could not take place as DG was on leave. **The panel is concerned** that the lack of meaningful impact in this case could be mirrored in relation to other patients on the ward. However, the panel recognises that staff were working in a high pressure environment, the more so because of the patient mix, and would often need to react to emergency situations and have to make crisis interventions.

3.21 The normal daily nursing notes contain a number of entries by the key worker, but they have no greater depth or insight than any of the other entries, nor do they in any way show any greater empathy with the patient. **The panel believes** that unless the key worker concept can be made to have more direct impact on the quality of patient experience, it will serve only to leave patients and their relatives dissatisfied, and will cause the system to be discredited.

Although the panel was assured that there was a care plan available during the admission, **the panel notes** that there was no nursing care plan in the notes of DG. **Members of the panel were surprised** by its omission. Such a care plan should be done by the key worker, and it would give staff a plan against which to judge progress.

3.22 DG was being cared for on Sunderland Ward. The panel accepts that Northowram hospital was a temporary location for the in-patient facilities, pending a move to new facilities in Calderdale Royal Hospital. From the information available to the panel, **members are concerned** that the ward was unlikely to be an ideal therapeutic environment. Leaving aside the age of the facilities, there appeared to be poor levels of staffing for the patient mix and numbers which were present on the ward. The panel heard differing accounts of staffing levels, but whatever the differences, all of the information received pointed to a staffing level which was too low. The panel believes that this in turn was likely to result in a passive environment, where little more than custodial care could be offered.

3.23 In these circumstances, **it is difficult for the panel to envisage** how much useful work could actively have been undertaken with DG. All efforts to persuade him to engage in occupational therapy activities were to no avail, but in the absence of a documented care plan, it is difficult for the panel to know what the relevance of this activity would have been. **The panel believes** that the lack of therapeutic activity was compounded by the lack of a properly documented therapeutic plan as part of the care plan.

3.24 **The panel is also of the view** that there were many times during DG's stay when the amount of nursing cover on the ward may not have been adequate, given the size of the ward and the likely patient mix, especially if some of the patients were on high levels of observation.

3.25 In such an environment, when DG's family came to visit him, having little experience of in-patient mental health facilities, they were unhappy about the apparent aimlessness of the regime. In an effort to give him some change from the ward environment, they occasionally took him out of the hospital in the evening. The panel can find no note of such outings in the hospital notes. **Panel members are disconcerted** that the ward regimes could be so unstructured that no-one would have been aware that DG was going out. **The panel recognises** that DG was an informal patient, but nevertheless considers that it is important that ward staff should be aware of the whereabouts of patients.

3.26 **The panel has tried to gain an understanding** of the extent to which ward staff sought to engage with the family, to understand better the dynamics of the family and the home environment. Although the panel is aware that DG's wife attended some ward rounds, there is little in the notes which would indicate that any meetings or conversations took place with family members, and this is borne out for the panel by comments made by family members in the oral discussions with the panel.

3.27 On one occasion, one of DG's daughters from his first marriage, had telephoned asking to see the consultant. An appointment was apparently willingly made for her to see Dr S, the consultant psychiatrist, but there is no note of their subsequent meeting or the content of it in the clinical notes. Even where such meetings take place away from the ward environment**, the panel would urge** that a note of the meeting should be placed in the clinical record.

3.28 **The panel considers** that more effort should have been made by the key worker and other ward staff to have a sound understanding of the family dynamics, and to seek to relate to relatives of the patient.

3.29 **The panel can find no evidence** that contact was made with DG's wife following periods of leave to determine how well these had gone, and to elicit any useful feedback she may have. It may be that some of these matters were discussed at ward rounds, when on at least one occasion, DG's wife was present. If such discussions did take place, then the notes do not record them**. The panel considers** that the objectives to be achieved by granting leave should have been made clear in the notes, and the success or otherwise of achieving those objectives should be similarly documented. **The panel is particularly concerned** that there was no structured feedback after leave because on one occasion when DG was at home, he had alarmed his wife by searching through the house for razor blades. This had sufficiently worried her so that she then began to move things so that DG would not find them. This information would not be known to ward staff, as there was no structured feedback after leave.

3.30 Throughout DG's stay in hospital, E, the CPN remained closely involved in his care, and was generally available to attend ward rounds. He had clearly given thought to child protection issues, as his notes indicate that he had spoken about these matters with DG's wife on 18 August 1998 when she was at the hospital for a ward round. His notes indicate that the ward had informed Social Services, and he notes that he telephoned V at Ovenden Social Services. This was with a view to organising a meeting with DG's wife and a social worker on the occasion of the next ward round on 25 August. M was the nominated social worker.

3.31 Dr S, the consultant psychiatrist's notes from the ward round of 18 August state that "E arranged a meeting with Social Services regarding the child protection". The undated equivalent entry in the ward round notes makes no mention of child protection issues, but nursing staff should have been aware of the on-going importance of the issue, as the nursing assessment completed by the first nurse, when DG was admitted had filled in information in paragraph 15 - Any possible child protection issues - an entry which concluded "says he sometimes thinks about killing his son if he kills himself". This entry also notes the telephone number for the Duty Child Care team (Ovenden).

3.32 The matter of child protection was clearly therefore flagged up as an important issue for the ward round of 25 August, and for the meeting with E, the social worker.

The exact timing of the meeting between the CPN E, M and DG's wife is not certain, but it may have taken place during the ward round, although separate from it, or following the ward round. The CPN's notes record that "there are no child protection issues as DG is receiving treatment on the ward". Dr S, the consultant psychiatrist's notes record that "E has seen DG's wife with the Social Services (M) and discussed the child protection issue. M is going to arrange child team to reassess the needs of the child". The ward round notes state that "assessment of child's needs is going to be done. The CPN says that there is not a child protection issue - he will discuss this with social services. (Son is mentally handicapped)." Both Dr S's note and the ward round note indicate that MG's needs are to be reassessed. M did not make a note at the meeting but later she made a note in the Detail Record, which makes no mention of child protection issues.

3.33 **The panel regards** this meeting on 25 August as being of major significance, in that it was a point at which Social Services could have been brought more to the forefront of the care and support for DG and his family. When child protection issues occur around patients with mental health problems, and the mental health professionals have involved Social Services, the panel accepts that it would be appropriate for the social workers to take the lead regarding child protection. **The panel therefore considers** that this was a significant lost opportunity in this case.

3.34 At no point in time did any of the key players make contact with the Trust child protection doctor or child protection nurse. **The panel was concerned** that there may have been some lack of understanding at that time about the role of the child protection doctor and nurse. At meetings with the panel, both the CPN and Dr S appeared to indicate that they would have thought to involve these professionals if there had been evidence of physical or emotional or sexual abuse of MG. One of the nurses from the ward appeared not to know anything about the existence of this support service within the Trust. **The panel therefore has some concern** that at that time, the role of the child protection doctor and child protection nurse may not have been well understood or known about, and not well communicated to staff, although it accepts that contact with the child protection doctor or nurse was not mandatory at that time.

3.35 Several key points emerge from this rather confused picture about the child protection issue which arose for consideration during DG's in-patient stay. First, **the panel considers** that it is unfortunate that there was no ward nursing input or medical staff input into the meeting with DG's wife. Members of the panel accept that the CPN may have limited the meeting to himself and M for very well motivated and kindly reasons, but an opportunity was lost for ward nursing staff and medical staff to be better informed about the wider dynamics of the family. Involvement of a wider range of staff would also have reinforced the necessity of communicating with Social Services at key points during the care of DG, particularly when leave was being planned and on discharge and would perhaps have clarified the issue of who should take responsibility for such communications.

Wider involvement of other staff would also have permitted some discussion about contingency plans. A multi-disciplinary discussion would have ensued, giving M an opportunity to take on a wider range of views.

3.36 Next, **the panel is of the view** that the meeting between E, M and DG's wife lost its focus in the minds of the professionals, as the CPN and M had so clearly formed a view that there were no child protection issues. The focus seems to have switched much more to supporting DG's wife, both in terms of helping her with her mother, and finding respite care for MG. Laudable though both of these aims were**, it is not clear to the panel** why the focus should have changed in the way it did, particularly when only a week earlier, the child protection issue appeared to have been at the forefront of everyone's concerns**. The panel recognises** that DG was accepting treatment, and that DG's wife had the care of MG. Nevertheless**, the panel considers** that the result of this meeting taking place may have been to falsely reassure other ward staff that the child protection issues had now been resolved.

3.37 The panel is unable to understand how the CPN formed the view that there were no child protection issues, as there is nothing in any of the notes to indicate how he made this judgement. If it was on the basis of discussion with M that there was no current risk as DG was presently an in-patient, then **the panel is concerned** that none of the accounts of the meeting make this point clear. In any event, given that DG could be given leave at any time**, the panel considers** that such a basis for the view that there were no child protection issues was unsound. Although M may have believed that DG would not be given leave if it was thought that he posed a significant risk either to himself or others, there was nothing in her notes to flag up what should happen if leave was contemplated.

3.38 M had been asked to attend the meeting of 25 August as duty officer. V's note in the daily record, dated 18 August, states "joint visit so they can inform DG's wife the exact concerns and why they referred" and later in the note, it states "DG's wife is fully aware of her husband's health and the concerns". In the light of this latter note, **the panel is disappointed** that M was content to go away from this meeting with points relating to the support of MG and DG's wife's mother, but not with any clear plan relating to DG, nor with any particular note which could be clearly said to allay "the concerns".

3.39 The panel have also had the opportunity to discuss with DG's wife her recollection of the meeting with the CPN and M. DG's wife recalls the meeting as being rather "heavy", and it filled her with concern that MG was going to be taken into care. When DG's wife's recall of the meeting was described to M, she was surprised, because in her recall, the child protection issue had been disposed of in a discussion in the corridor on the way up to the meeting. She had confirmed to her own satisfaction that DG was continuing as an in-patient, that MG was in the care of his mother, and therefore in her view, there was no current child protection issue. This matter was left between them on the basis that the CPN should call Social Services if they were needed.

3.40 **The panel believes** that the child protection issue had been expected to be at the heart of the meeting with DG's wife, and it was unsatisfactory that matters should be left so loose in connection with this issue. There was no clear plan about who had to be contacted, or by whom, or when. No discussion ever took place about the possibility of needing to reconsider the child protection issues if DG became well enough to take home leave. All in all, **the panel considers** that the handling of this issue is one of the most unsatisfactory elements of the whole case.

3.41 Further elements of the Social Service involvement, or lack of it, following M's meeting, are developed later in this report, in the sections dealing with the Community Mental Health Team and Social Services input.

3.42 As DG made progress and improvement during his in-patient stay, the question then arose of him being able to go home on leave. There is no evidence that anyone in Social Services was ever informed about any of these periods of home leave, despite a note in the nursing notes that "Ovenden's Child team informed of possible risk to handicapped son. They asked us to inform them if DG goes home for any reason." **The panel considers** that there was a significant failure by nursing staff in not alerting the Ovenden Social Services. **The panel also believes** that the multi-disciplinary team should have been working in such a way that all pertinent issues relating to DG were flagged up at each multi disciplinary team meeting, so that Dr S, the consultant psychiatrist was aware of these issues and therefore able to take a stronger leadership role within the team. Ward rounds were an opportunity when these matters should have been discussed **and the panel considers** that such an opportunity was lost because the ward rounds appear to be a heavily medical model, strongly focussed on DG's clinical presentation.

3.43 Throughout his period in Northowram hospital, DG was under the care of Dr S, the consultant psychiatrist, who is the responsible consultant for the North Halifax district. He has held this locum appointment since 1995, having worked in Halifax since 1983. It was clear from the panel's meeting with Dr S that he had a good recall of DG's care, and was caring, well intentioned and committed to his well-being.

3.44 Over the period of DG's in-patient stay, Dr S and his team saw DG regularly on ward rounds. The clinical notes are relatively brief, with little emphasis on wider issues. The ward round usually involved three doctors, a nurse from the ward, the CPN or someone from the CMHT team, and occasionally DG's wife attended. The panel considers that Dr S, the consultant psychiatrist, had good working relationships with the CPN, and provided good continuity of care for DG.

3.45 The panel has noted that there were times when DG's medication had been increased following a later domiciliary visit. **The panel considers** that it would therefore have been appropriate to follow him up in out-patient clinic more quickly than the two month follow up which occurred.

The panel accepts that Dr S, the consultant psychiatrist had intended to follow up more quickly, at an out-patient appointment on 2 June, but DG cancelled this appointment. The panel believes that it would have been helpful if this fact had been noted in DG's clinical notes.

3.46 Neither Dr S, the consultant psychiatrist nor anyone from the multi-disciplinary team created opportunities to see DG's wife separately, although the panel accepts that Dr S did have the opportunity to speak to DG's wife outside her home as he was leaving on 20 May. Dr S was confident that she could express her views and concerns without reservation. At his last domiciliary visit to DG, on 20 May 1999, Dr S was convinced that it was her true wish that she did not wish her husband to be admitted to hospital**. In the view of the panel**, DG's wife had not been given sufficient information during DG's illness to permit her to form a proper judgement on this matter, as she had not had any evaluation of the risk to MG. Moreover, her view may well have been coloured by her and the family's experiences of DG's previous in patient stay.

3.47 After three successful and increasingly lengthy periods of home leave, DG was then ready to be discharged from Northowram. Pre-discharge discussions took place on 15 September on the ward round, when DG was due to go home for a week's leave. The plan noted at that time indicated that "if leave was OK, discharge next week. E, CPN keyworker, CPA level 2, OPD 2/52." The notes for 22 September indicate that DG was "discharged as arranged above". **The panel notes** that there was no discharge care plan drawn up, nor a discharge risk assessment and cannot therefore be certain what was the role of the key worker**. The panel also notes** that there is a blank CPA form in DG's in patient records.

3.48 The discharge letter was written by the Senior House Officer, and dated 14 October. Because of delays in typing which occurred at that time, a computer generated discharge sheet was sent to the GP at the time of discharge. The panel has seen the sheet concerned, and does not believe that it would be of any significant help to a GP. Apparently this system is no longer in use in the Trust. This is to be welcomed.

3.49 **In the view of the panel**, the SHO's discharge letter was in some respects rather deficient, in that it failed to mention the original reason for the referral, the homicidal thoughts in relation to MG, or that the possibility of treating DG with ECT had been considered on at least two occasions. This latter point would have been helpful to the GP in judging the severity of the depression. The letter also fails to mention the meeting with Social Services which had taken place, involving DG's wife, the CPN and M. **The panel regards** these matters as significant omissions from the discharge letter.

3.50 In hindsight, the SHO had realised that the letter was less than adequate, and with that in view, he had sought to correct any limitations by points he made in a later letter to the GP, after an out-patient appointment in March 1999**. In the view of the panel**, the result is somewhat unfortunate, in that it makes the later letter rather disjointed and seemingly self-contradictory.

The panel believes that the SHO has taken a number of important lessons from his own acknowledged shortcomings in the discharge letter, and is encouraged by his positive recognition of this.

3.51 **In the view of the panel**, the most worrying feature of DG's discharge relates to the failure to let Social Services know he was being discharged. There appeared to be a lack of clarity about who had to be informed, by whom, and when. These issues will be pursued in relation to the Community Mental Health Team and Social Services input to the care of DG.

3.52 During the period of his in-patient stay, **the panel accepts** that DG made progress relatively quickly. His depressive illness improved, and his mood became lighter. However, this does not alter the **view of the panel** that the general in-patient environment was passive and lacked direction and leadership. **The panel would welcome** Dr S, the consultant psychiatrist and the ward manager taking a more assertive stance on the therapeutic environment. **The panel is not reassured** by the fact that the ward has now been re-established in more modern facilities, as it appeared to be the case, from information gathered during the oral hearings, that the patient mix is now even more unsatisfactory than it was previously. **The panel would also be concerned** if the somewhat passive culture previously prevailing at Northowram had been transferred to the new setting.

3.53 Members of the panel are fully aware of the difficulties which have existed over a number of years in regard to the recruitment of consultant psychiatrists, but **the panel considers** that this long standing locum arrangement should be reviewed, and efforts made to recruit substantively to this post. Although Dr S, the consultant psychiatrist does not consider that his position as a locum consultant has compromised his relationship with the Trust, **the panel considers** that it may have prevented him from taking a more assertive stance with the management of the Trust, both in terms of the patient mix on the ward and the staffing levels.

Community Mental Health Team and CPN

3.54 E was the CPN with continuous involvement with DG from 9 June 1998, when he had been asked to see him by Dr S, the consultant psychiatrist. His first meeting with DG was on 19 June, but there is no note of this meeting in the CPN's notes. The record of the meeting consists of a letter written to Dr S, the consultant psychiatrist, and copied to Dr C at the GP surgery. Some factors contributing to DG's stress are flagged up in the letter, including the fact that DG and his wife "have a 12 year old handicapped son who has appropriate support services". DG's wife was present at this assessment.

3.55 When the CPN was present at Dr S's review of DG in out-patients on 2 July, his notes indicate that DG had made some improvement, and there would be "no further follow up from CMHT." The panel recognises that DG would continue to attend Dr S's clinic, and would have access to the Community Mental Health Team. The panel has also taken account of the fact that DG was returning to work.

However, i**n the view of the panel**, this conclusion, for no further follow up, was unsatisfactory, given all the issues that the CPN had flagged up in his letter to the GP.

3.56 When the CPN returned from leave, he discovered that R from CMHT had been summoned on an urgent response referral to see DG at home on 21 July. There was a letter on file from R to Dr C, and copied to Dr S, the consultant psychiatrist. R had also completed an urgent referral form which contained some useful information. Apart from this occasion, and one other when assistance was given by a duty officer during a period of the CPN's leave, all contact with the CPN service and the CMHT was with E. **The panel is satisfied** that this should have provided good continuity of care for DG.

3.57 When reviewing the period over which the CPN had contact with DG, some commendable features emerge. **It is clear to the panel** that E had very good working relationships with the GPs in the practice which looked after DG, and that he had a good and close working relationship with Dr S, the consultant psychiatrist. When necessary, for example in relation to the admission of DG to Northowram hospital, these close working relationships worked to the advantage of the patient. This is to be commended. He also showed some tenacity in trying to galvanise the social worker into some activity about respite care for MG.

3.58 In general, the CPN's notes are satisfactory. However, **the panel is of the view** that the notes demonstrate the rather narrow nursing focus in this case, and there is little evidence in the notes that he took advice on the social dimensions of the case. In consequence, although his team working with the GPs and the consultant and his team at the hospital was sound, **the panel finds that** there is less evidence of such an effective interface with social workers.

3.59 **The panel is concerned** that in consequence, the CPN had a limited view of the wider family issues, and the extent to which these could have been causes of stress and pressure for DG. It was only during a meeting with M during DG's in-patient stay that the CPN appears to have actively tackled the pressure on DG's wife because of needing to give some support to her elderly mother.

3.60 Although DG's wife may have been present at a number of the meetings which the CPN held with DG, **the panel has no impression** of an effective therapeutic relationship having been created with her. He does not appear to have sought opportunities to speak with DG's wife on her own. Although his view may have been that he related effectively to DG's wife, and she did telephone him on a number of occasions, her perception was that she did not feel personally supported by the CPN's visits.

3.61 As time went on, and it became clear that DG's problems were further compounded by the chronic back pain he was suffering, **the panel considers** that it would have been helpful to have undertaken a general social assessment or carer's assessment.

The need for this is reinforced in the view of the panel by the care plan which the CPN formulated in March 1999, when he had identified carer needs during his assessment, and noted "provision of support to DG's wife". This assessment was due to be undertaken again in June 1999, but had been deferred, presumably due to annual leave. **The panel considers** that the urgent need for this re-assessment should have been apparent when the CPN visited on 3 July, and it is a matter of regret that it did not occur more promptly.

3.62 Although **the panel considers** that the CPN's notes were adequate, and recognises that he was in reasonably regular contact by telephone with GPs and Dr s, the consultant psychiatrist, **the members of the panel believe** that his records would have represented a more rounded account if he had written formally on occasion to others involved in the care of DG**. The panel believes** that this would have been particularly appropriate in March 1999 when the CPN had carried out a risk assessment, determined a HoNOS score, and formulated a care plan, as it is uncertain whether he ever shared this information with the other professionals involved with DG. **The panel also considers** that the care plan would have been more valuable as a working tool if it had contained indicators on regulating outcomes, although it accepts that this may have been possible to a limited extent by continuing to score regularly on the HoNOS scale**. The panel recognises**, however, that the HoNOS scale is not designed to be an adequate means of regulating outcomes.

3.63 **The panel also reflected** on some issues of more general concern with regard to the Community Mental Health Team. The first of these relates to opportunities for multi-disciplinary discussion of cases within the team. Given the concerns already outlined about the somewhat narrow nursing focus in the CPN's notes, **the panel considers** that maximum advantage of the professional mix in the team was not being achieved, as there was no regular forum for case discussions. The team regularly met on Mondays for the allocation of work, and the panel was informed that on some occasions, it was an opportunity for team members to discuss clients of concern. **The panel does not accept** that this was an adequate forum for case discussions.

3.64 However, the principal business of this meeting was allocation of cases, and **the panel does not consider** that it could operate effectively as an alternative to structured opportunities for properly minuted multi disciplinary meetings, which could have added greatly to the learning experience and perspective of all the members of the team. **The panel considers** that without such opportunities for a multi-disciplinary perspective, there is a danger that each member of the team could lose some of their professional value, and their expertise would not be fully maximised and utilised.

3.65 Another wider team issue **of concern to the panel** was the question of which members of the team should take part in the emergency rota. It is clear from a visit made by R, a social work member of the team, in response to an urgent referral of DG, that he was on the emergency rota. The panel also reflected on whether it is appropriate for the occupational therapist to be on the emergency rota.

This may be entirely appropriate given the individual concerned, but **the panel believes** that more thought may need to be given to who goes on the emergency rota, and how the selection is made.

3.66 **The panel does not wish to cast any doubt** on the appropriateness of R's response when he visited DG. In the light of what he knew when he went, his notes, combined with his letter to the GP were enough to alert and inform all concerned with the care of DG. His letter is thorough, and he did follow up his visit by sending the material he had promised.

3.67 A further wider team issue of concern relates to supervision arrangements for members of the multi-disciplinary team. Although **the panel was at pains** to attempt to understand the systems in place, its members are left with an overwhelming impression that the arrangements were poor and not adequate. The CPN appears to have had only peer supervision. There is no evidence of any systematic review of cases. **The panel is of the view** that the arrangements for supervision were ad hoc. There is no evidence of a trust wide system of supervision operating at that time, and **the panel is unsure** whether better systems are effectively in place now.

3.68 There was a CPA process in operation at that time, but in **the view of the panel**, it was not effective. **The panel is critical** of some of the documentation used, in particular the data summary sheet generated by computer. Reviews did not appear to take place frequently, and there is no helpful documentation available with regard to DG until March 1999, when the CPN undertook a risk assessment and drew up a care plan. However, this was not then distributed to key professionals connected with the care of DG.

Social Services Involvement

3.69 A particular feature of this case has been the way in which the family needs appear to have been a low priority for Social Services despite being assessed as in urgent need. This is evident throughout by the very leisurely pace at which the case is progressed. **The panel is of the view** that the systems operating in Social Services at that time were inadequate, in that they did not pick up and relate later information to earlier contact which had taken place with the service.

3.70 It can be argued that the failure of social services to deal effectively with DG's wife's request for respite care is outwith the scope of this inquiry, but it should be recalled that both DG and his wife were noted in the Social Services file to be carers of MG. The first request for respite care was made in September 1996, but no-one went to see the family at that stage. Some early work in relation to obtaining an orange badge and benefits was undertaken by N, but when she transferred the case on 18 December 1996, it appeared that nothing had been done to initiate the respite care application. It was not until 19 May 1997 that the Respite Care Panel allocated 30 nights respite care at Linden Brook. **The panel considers** the delays in dealing with the request for respite care were excessive.

3.71 This allocation of respite care was made on the basis of an assessment which had been done by a student social worker, T. The summary sheet in the assessment notes that the degree of challenge to the parents was high, as was the level of stress/depression/family disruption. There are a number of pertinent comments in the assessment under the heading "Behaviour", where it is said that MG's parents are finding MG much more difficult to handle as both they and MG are getting older…….MG needs constant attention, and to get attention will pull and drag his parents or shout at them. This he will do constantly wearing his parents down until he gets what he wants. Both parents find it difficult to relax while MG is about ………They do not get any evenings on their own."

3.72 In section 3 Carers' Assessment, the report notes that DG has a bad back that has been aggravated by caring for MG…….DG's wife feels that she has to be fit and well as she has to care for MG and then at times has also to care for her husband and for her own mother who is in her eighties and living on her own. The report goes on to say that DG's wife sometimes feels like screaming as MG's behaviour can wear her down so much. Holidays are also stressful as it is so difficult for DG's wife to check on her mother and look after MG at the same time as their needs are so different.

3.73 The report further notes that "DG and his wife have very little time for each other. The stress and the tiredness can lead to arguments as they just don't have time to talk things through." **The panel is of the view** that the work undertaken at this time by the student social worker, T, was supportive of DG and his wife, her assessment report was thorough, and her input was appropriate to the situation prevailing at that time.

3.74 The panel have assumed that this report at a minimum would have been information available on a file relating to MG, and could have informed the thinking of Social Services personnel when subsequently there was a referral relating to DG.

3.75 When DG was admitted as an in-patient at Northowram hospital, a nurse from the hospital made a phone call to Social Services on a date noted to be 12 August 1998. The panel has assumed that this date is incorrectly recorded in the Detail Record, as DG went into hospital on 13 August. The gist of the message was to inform Social Services that DG "has mentioned that he has had suicidal thoughts and anxieties. One anxiety is what would happen to his son MG if he was not around. One of the thoughts he has had is that if he were to commit suicide he would take MG with him". Later in the same note, it is reported that the ward was requested "to keep us informed of progress. Implied that even if there are improvements, may be some continued element of concern as external pressures, stress re son will not change." This entry, as with all the other entries in the Detail Record, is identified only by the initials of the person making it**. In the view of the panel,** it is not satisfactory to use initials only. The person making the entry should enter their name in full, and should indicate their own status in relation to the entry, for example if they were acting as the duty officer. Where information has been sought or received from another source, the entry should also indicate that person's full name and job title.

The note taking system, when typed up in the Detail Record, does not make clear when one entry finishes and another begins, making it difficult to identify which steps were being taken by which member of staff. **The panel believes** that entries should be more clearly separated.

3.76 The action plan on the Detail Record at this point notes that "contact will be made with the Ward next week to discuss plans for DG's discharge and how we can become involved in terms of contributing to a plan of support services to be offered to the family." A telephone call was made to the ward on 17 August, and this elicited the information that Dr S, the consultant psychiatrist was seeing DG the following day. Matters were left that the CPN would contact Social Services after the meeting with Dr S. By this stage, messages in Social Services had been taken by four different duty officers in this case. The panel has heard evidence about the systems in place in the Social Services team involved to deal with calls coming in to the duty officer. However, that system could not provide a consistency of input, and **the panel believes** that it was unfortunate that this case was left in the duty system and not specifically allocated to a social worker earlier. This would have ensured that the key meeting at the hospital on 25 August would have been attended by a person with on-going responsibility for the case, and that there may have been more effective follow-up once DG was discharged from hospital.

3.77 When the CPN telephoned on 18 August, he indicated that DG was likely to be in hospital for another four weeks. He referred to the prospect of ECT treatment. He indicated that DG's wife was aware that Social Services had been contacted. He agreed to keep Social Services informed of DG's progress. The action plan which emerged from this discussion was that a joint visit should be made to see DG's wife, to inform her of the exact concerns and a home visit**.** **The panel is of the view** that the information that he was severely depressed and agitated, combined with the earlier note about threats to his own and MG's life, and that ECT treatment was being proposed should have been a trigger to alert Social Services to the apparent seriousness of DG's condition. Social Services also had available to them the report prepared by the student social worker, T, which had been prepared a year earlier, and which indicated a high level of stress on DG and his wife as carers of MG. **The panel is of the view** that on the basis of this information, Social Services ought to have considered instigating the Child Protection Procedure. If a decision were then taken not to proceed in this way, a note of the reasons should have been put on the file. Short of instigating the full Child Protection Procedure, **the panel is of the view** that a planning meeting would have been useful, in that it could have taken account of DG's current needs as a carer.

3.78 The plans set out in the Detail Record did not materialise. It is unclear to the panel why this was the case, but the way forward was probably decided as the result of a decision taken by a senior manager or team leader in Social Services when reviewing the Detail Record. **The panel considers** that the lack of any note on the Detail Record, showing the points at which some check or intervention had been made by a more senior person, is a significant omission.

The panel does not doubt that such checks and reviews took place, but it would have been good practice to note them in some way in the record. Instead of what had been planned in the Detail Record, the meeting at the hospital, involving E, the CPN, M and DG's wife took place. **The panel considers** that it is unfortunate that the original action plan was not adhered to. This would have given Social Services an opportunity to meet with DG's wife in her own home, on her own, when it may have been more likely that a full and proper assessment on a more holistic basis could have been undertaken. This may have resulted in a regular follow up from Social Services in relation to DG's discharge. Moreover, **the panel believes that** such a meeting would have been a useful opportunity to gauge DG's wife's understanding of the issues, and to ensure that she understood the possible risk to MG. This could have been especially significant at later stages when she was asked if she wanted DG to go back into hospital. **The panel is of the view** that her opinion may well have been significantly different if she had had a better appreciation of possible risks.

3.79 The meeting at the hospital on 25 August has already been described. **The panel considers** that the note made by M following the meeting was completely inadequate and rather misleading about the nature and content of the meeting, insofar as the emphasis of the note focused on respite care, and gave no indication of what had been discussed or decided on the child protection issue. **The panel is of the view** that the note would have given no real indication to a duty manager as to what next steps should be taken in this case. If a discussion about this case with senior staff on duty at that time did take place, then this discussion and its outcome should have been recorded.

3.80 **The panel is also concerned** at the distinction made by M between a formal and an informal meeting. Further clarification of this point drew out that her visit to see DG's wife at the hospital was essentially a home visit. The panel is also concerned at the suggestion that a home visit would not be a formally recorded meeting. Moreover, even if the respite care issue had been the main focus of the meeting, there is no evidence anywhere in the files to show that M or anyone else in Social Services did anything to carry this matter forward with any degree of urgency.

3.81 Although the notes make no mention of any information given to DG's wife about making further contact with Social Services, it is DG's wife's recall of the meeting that she was told to inform Social Services when DG was discharged. In fact, she did so, but the person who took her message knew nothing about her, and did nothing about the message. If it is the case that DG's wife was told to make contact in this way, **the panel considers** it to be wholly inappropriate that the burden should be cast upon her at a time when she was likely to be under additional stress and responsibility.

3.82 M's note of the meeting on 25 August indicates that "The CPN will support DG following discharge". This is the only reference to what will happen after DG's discharge from hospital. **It does not appear to the panel** that anything was done by Social Services as a consequence of the meeting of 25 August to reinforce that they would be told of DG's discharge.

It could be argued that a consequence of the meeting on 25 August was that M had been reassured by the fact that DG was an in-patient that there were no current child protection issues. **The panel is concerned** that a responsible professional person would make no further arrangements to ensure that discharge arrangements were communicated to Social Services, nor communicate that need in her record of the meeting. The panel has taken account of the fact that following discharge, DG was well enough to resume work, but this could not have been anticipated when the meeting of 25 August occurred.

3.83 **The panel wishes to reinforce its view** that this crucial date, 25 August, was a significant opportunity lost for Social Services to become centrally involved in the support and care of this family. **The panel has taken account** of the information which would be available to M before she went to this meeting. The information is clearly there about DG having thoughts of suicide and thoughts of taking MG with him. The seriousness of DG's mental state can be judged by the information that Social Services had that he was severely depressed and agitated, that he was likely to be in hospital for four weeks, and there was the prospect that he may require ECT treatment. Those factors alone should have been sufficient to ensure that the social worker was not so easily satisfied that there were no child protection issues. **The panel is of the view that** the note put on the Detail Record is so bland that it would not be likely, of itself, to alert a duty manager to the need for more vigorous follow up. Moreover, **the panel considers** that the limited range of people who attended the meeting of 25 August in itself militated against the likelihood that the need for a multi-agency review would be identified.

3.84 **The panel accepts** that it can be argued that after this in-patient stay, DG made significant progress, sufficient to permit him to go back to work for a period. It could therefore be said that nothing was lost by the failures outlined above. **The panel however believes** that much was lost, because the Social Services file gave an inappropriate impression in relation to this case, and this may have influenced the vigour, or lack of it, with which subsequent work was undertaken.

3.85 When H took over the file in September 1998, he indicated to the panel that when the case was allocated to him, he had been told to liase with the CPN from the mental health team, because "dad had had a breakdown and there were some concerns that he had threatened or talked about killing himself and his son." When he did speak to the CPN, he noted that DG was "a middle aged businessman who felt like killing himself and taking his son with him. He is being treated and the main issues have been resolved……..There are no child protection issues at this time but the family needs support and input". He appeared to believe that his priority was pursuing respite care for MG. **The panel considers that** he did this in a rather desultory fashion, with a number of apparently much needed prompts from the CPN.

3.86 **The panel is concerned** that the social worker would accept that there was no child protection issue in this case without questioning it further. The panel accepts that H was a relatively inexperienced social worker, but nevertheless notes that opportunities were not taken to discuss this case in supervision. However**, the panel accepts** that other more senior colleagues had had sight of the information in the file, and had not picked up the child protection issue, and notes that it was not picked up on the transfer of the file. In hindsight, H acknowledged that with the information available to him, it would have been sensible to insist on some kind of multi-agency meeting or review. **The panel appreciated** his honest acceptance of this point.

3.87 H was also asked for a new assessment of need. The request came from the Acting Head of Children's Services. She needed the documentation for the Respite Care Panel, and had specifically said that she was requesting a new assessment because in the case of many of the children concerned, circumstances have changed significantly since their original assessment.

3.88 This would be true in the case of MG. Since May 1997, when the student social worker did the original assessment, MG's father's physical health had deteriorated significantly, and he had had a spell as an in-patient for his mental health problems. However, although this reassessment, done in February 1999 made reference to DG's belief that many of his problems have been caused by worrying about MG, there was no more expanded analysis of the type of threats he had been making with regard to MG.

3.89 H sought up-dated information for his re-assessment from other agencies, including the GP. The form returned by the GP, Dr K, made no comment about family circumstances. This may be due in part to the range of questions he was asked to complete, which would not of themselves indicate that wider, social factors were being enquired about. Nothing on the form itself, nor in H's accompanying letter, indicated that information was being sought to support an application for respite care. The relevant question on the form simply states "Any other information". **The panel is of the view** that the questions on this form need to be more specific in detailing examples of the sort of information which was being requested. **The panel is also of the view** that as H was aware of the involvement of the Community Mental Health Team and the CPN, it was appropriate for him to have sought up to date information from them as part of his re-assessment work, as DG was one of MG's carers.

3.90 H also met with DG and his wife on two occasions when he was preparing the assessment. These meetings were likely to have taken place in January 1999 or early February. **The panel was mindful** that at that time, DG had returned to work, and therefore when H saw him, he gained an impression that DG was a lot better.

3.91 H had qualified as a social worker in 1995. **It seemed to the panel** that he suffered from a lack of structured supervision permitting review of the whole spectrum of his case load, a point to which the panel wishes to refer more generally at a later stage.

The panel has formed the impression that he was rather passive in the resolution of the respite issues. Although supervision arrangements were somewhat ineffectual at that time, it would have been possible for this case to be discussed in supervision, but it was clear that it was not discussed in any detail. If referred to, it was only to comment that it was awaiting transfer to the disability team.

3.92 The panel is not aware that there was any arrangement for management review of cases awaiting transfer. Even when the case was ready to be transferred, it appears that nothing was done on it, as Social Services were in the process of being reorganised, and the new team which would take on this case was not in place at that time. Given the high priority which H had accorded to this case "urgent due to father's recent breakdown", **the panel is concerned** that this was not noted and acted upon by his senior manager.

3.93 **The panel is also concerned** that H's file notes do not give any indication of why he was transferring the case, which is believed to relate to the reorganisation which was taking place at that time. It also appears that he did not inform the family that he was no longer dealing with the case. **The panel believes** that it would have been good practice to have informed the family. As it was, the first they knew about this was when they received a letter written on 29 June 1999.

3.94 That letter informed DG and his wife that a new team, the Children with Disabilities team was being developed but at that time, it was not fully staffed, and "there may therefore be some delay in allocating a worker to assist you and your child." The letter confirmed that cases were being prioritised so that "those in most urgent need will be allocated a worker at an earlier stage." Given that the family had learnt in March 1999 that MG had been assessed as being of the highest category of need, when his case had been before the Respite Panel**, the panel is concerned** why this assessment could not have been used on an interim basis, with a speedy allocation of a worker to the family.

CHAPTER FOUR

THE RANGE OF SERVICES AVAILABLE AND THEIR ORGANISATION

4.1 At the time of the incident being reviewed by the panel, DG was resident in Halifax. The commissioning authority for health services at that time was Calderdale and Kirklees Health Authority. The panel has received information about the organisation of both in-patient facilities at Northowram Hospital and the operation of the Community Mental Health Teams in Calderdale at the time of the incident. The panel has also considered the organisational arrangements which were current in Calderdale Social Services at that time.

Community Mental Health Teams

4.2 Joint teams had been in place since early 1996, following the receipt of an Audit Commission Report in October 1995. There were four adult teams which were sectorised, divided geographically to groups of GP practices but not to electoral wards. The Keighley Road practice, of which DG was a patient, fell into the Halifax North Community Mental Health Team. The team served a population of about 32000 adults. There were separate teams in place for Child and Adolescent Services.

4.3 The target population was based in seven or eight general practices, some of whom were single handed practitioners. The area has a high incidence of mental health problems, due to socio-economic factors, and there is deprivation. It was reported to the panel that the greater part of the criminal activity in Halifax is within this area, and it has the highest concentration of council owned property.

4.4 The Community Mental Health Teams were multi-disciplinary. Dr S was the consultant psychiatrist, and E, the CPN, was the co-ordinator. There were nurses, social workers, support workers, occupational therapists and an administrator in the team. It operated out of Beechwood Community Health Centre, in Keighley Road, Halifax.

4.5 The post of co-ordinator in the teams was new in February 1997, to help to steer the development of integrated teams using a single unified assessment incorporating care programme approach and care management.

The description of "current range of responsibilities" for the CMHT co-ordinator includes among its headings "Allocating work/cases in accordance with jointly agreed procedures", "Ensuring implementation of agreed procedures for referrals, assessments, care planning, case reviews and closure", and "Organising team meetings".

4.6 Within the CMHT, there was a framework for responsibilities and lines of accountability. After listing the responsibilities of team members, the team co-ordinator and the professional line manager, the framework deals with those areas where the co-ordinator and line manager will need to co-operate and establish agreed working practices. These include: "Appraisal of performance and identification of training needs".

4.7 The professional line manager's responsibilities specifically include "professional supervision of specific interventions or issues of a particularly complex and/or sensitive nature".

4.8 The Community Mental Health Teams are jointly managed by two managers, one from the health service and one from social services. Relationships between health and social services were reported to be good. No particular problems were reported in developing joint operational policies or in establishing the lines of responsibility and accountability.

4.9 As the new joint working arrangements were developing, these good relationships are apparent in some of the supporting documentation. In a document issued by one of the project managers in respect of joint teams, it is clear that steps were being taken to develop a comprehensive unified assessment which would integrate CPA and care management provision in the CMHT's. Reciprocal arrangements for accessing partner agencies' computer systems were also being set up. The aim was that a GP referral would receive one assessment by the team, and may obtain domiciliary care from team staff addressing health and social care needs. A further development was to be the provision of Community Support Workers within teams, who would liase closely with the voluntary sector and would maintain a directory of local services which clients could access.

4.10 A subsequent document, issued jointly by Calderdale Healthcare NHS Trust and Calderdale Social Services Department setting out the operational policy for the Community Mental Health Teams, dated June 1999, builds on the earlier documentation. In a section headed "Section Four - Team Management and Supervision", it clearly states that "the team co-ordinator ensures that each CMHT member receives clinical supervision and has access to professional support outside the team if required." This 1999 document repeats the framework for responsibilities which had been developed in the earlier project document, including the point that team co-ordinators have responsibility for case management supervision and the professional line manager has responsibility for professional supervision of specific interventions or issues of a particularly complex and/or sensitive nature. These are the only places in the document which make reference to supervision.

4.11 When the panel met members of the CMHT, the question of supervision was discussed. As indicated earlier in this report, the panel members had difficulty in understanding what was in place at that time by way of supervision, and drew the conclusion that it appeared to be rather ad hoc. **Panel members attach particular importance** to the availability and effective use of supervision, particularly as staff at the time in question were accommodating to working in a more joint fashion, and accepting aspects of such joint working which may have extended them to the limits of their confidence and capability.

4.12 In the understanding of the panel, the situation appeared to be that team members had the right to seek clinical supervision, but there was no compulsion for people to accept it. It appeared to be rather unstructured in terms of who staff should turn to for such supervision. **The panel is of the view** that the lack of formal structures may have been a disincentive to people wishing to take up such supervision.

4.13 The Care Programme Approach guidelines, issued jointly by the Calderdale Healthcare NHS Trust and Calderdale Social Services Department, were issued in November 1995, and June 1999. They have subsequently been further revised in April 2001. The 1999 version was just in the process of being implemented at the time of the incident.

4.14 Under the 1995 version of the CPA guidelines, three levels of CPA were in operation. At times during his care, DG was on level 2, and then reduced to level 1. Considering the criteria for level 2, DG would be on that level either because he was suffering from severe mental illness or because he was assessed as suffering, as a consequence of his mental illness, a level of disability that required intensive support. Severe mental illness was described in this 1995 document as including major depression, which was at least one year since the onset of the disorder, sufficient to seriously impair functioning of role performance in either occupation, family responsibilities or accommodation. DG was discharged from hospital on 22 September 1998 on level 2 CPA.

4.15 At the time when he was discharged, under the prevailing 1995 version of CPA, the documentation clearly states that "no patient should be discharged from hospital until a satisfactory care programme has been developed. The key worker should receive a copy of all the Care Programming Forms, the original being retained in the casenotes. Copies of the Care Plan section should be sent to the client, the GP and any person identified as requiring a copy". Although there is a plan noted in the ward round records before DG's discharge, **the panel can find nothing** other than a computer generated discharge sheet which was sent to the GP which could be said to fulfil the above requirements.

4.16 The panel has already expressed its view that the computer discharge sheet was totally inadequate as a care plan. It appears to the panel that significant reliance was placed on the GP being informed by means of the consultant discharge letter. However, typing delays produced significant delays in the despatch of these letters.

A significant period of time could elapse when the GP would have no clear picture of the level of risk posed by the patient at the time of discharge.

4.17 The 1995 documentation also deals with the question of assessment for CPA. It states that all individuals on CPA will have as a minimum a health and social care screen (HoNOS), which may trigger further assessment. The same section states that "Efforts should be made to engage the service user and where appropriate their identified carer as fully as possible in the process of assessment, development of the care plan and subsequent review process." The document goes on to state that carers have a valuable role to play and those closest to a mentally ill person may be able to help the team in a number of ways, for example by identifying particular social care needs. The same section states "Carers often have difficulty expressing their fears when the patient is present and may initially have to be interviewed alone". **The panel is of the view** that the guidelines in this section of the document were not followed in relation to DG and his wife.

4.18 The 1995 document also notes the action to be taken when patients are being discharged from level 2 to level 1 CPA. "Patients to be discharged from Level 2 Care Programming or moved to level 1 should be the subject of formal multi-disciplinary care review. Reviews will allow for the revision and production of a new Care Plan". The document notes that such a review should involve the key worker, Consultant Psychiatrist, Social Worker and others involved directly in the care of the patient.

4.19 There is a note in Dr S, the consultant psychiatrist's clinical notes that at an out-patient appointment in December 1998, when DG was accompanied by the CPN, he reduced the level of CPA to level 1, and this is also recorded in the CMHT notes. There is also a letter on file from Dr S to the GP, reporting this change of CPA level. However, Dr S's entry in his notes does not make clear who was at that appointment. The panel have assumed that it was only DG, Dr S and the CPN. Panel members have also assumed that the combination of the entries in the notes and the letter to the GP constituted the new care plan. **In the view of the panel**, the care plan needs to be more formally identified, and more formally communicated to all concerned.

4.20 The advent of joint working between health and social services, with the integration of CPA and care management, and willingness to recognise that members of the CMHT could work in a holistic way was a time of significant change in working practices and philosophy. The panel believes that this time of change would impose a significant training requirement on members of the Community Mental Health Team, and particularly reinforce the need to undertake elements of joint training, in order to share perspectives on key aspects of practice. It has been difficult for the panel to establish exactly what was expected of staff in terms of training at that time, but it seems clear that there was no mandatory requirement then to undertake training in child protection issues. **The panel believes** that this lack of mandatory training in child protection issues led to some members of the CMHT forming a limited view of when they needed to seek help from the Trust Child Protection Doctor and Nurse.

4.21 Meetings of the CMHT took place regularly on Mondays for case allocation and caseload management. All members of the team would be expected to be present, and this meeting did afford opportunities for discussion with others on any cases causing particular difficulty or concern. This, however, was not the purpose of the meeting, and if this did happen, it was by chance, and would not in consequence be likely to be formally minuted or written up in a patient's notes. The other regular meeting was a business meeting for members of the team, which would be more about operational issues, and was not an appropriate forum for discussion or case review. The panel does not doubt that much informal discussion took place between members of the team. However, **the panel considers** that a formal case review meeting should take place at regular intervals, which is properly minuted. Members of the panel were pleased to learn that since the incident, more information exchanged at case allocation meetings is recorded in the patient's notes, but they still believe that this is no substitute for a formal case review meeting.

The in-patient service

4.22 At the time when DG required in-patient treatment, all the in-patient beds were sited at Northowram Hospital, some three or four miles outside Halifax. It was already known that this hospital would close, and that the in-patient beds would be re-provided at Calderdale Royal Hospital. Bed numbers would reduce to take account of re-provision of bed alternatives in the community.

4.23 The staff serving the in-patient facilities appeared to have been a stable workforce over the period in question, despite the amount of turbulence throughout the service. The Trust experienced problems which were identical to those being suffered by other Trusts nationally with regard to consultant recruitment. The panel was informed that the number and mix of nursing staff was regarded as satisfactory, especially given that the ward was an old style Nightingale arrangement.

4.24 Sunderland Ward had 24 beds, and within that number, there were beds for learning difficulties, drug and alcohol detoxification, beds for those with dual diagnosis, and child and adolescent beds. The ward had originally been designed as a rehabilitation ward. Bed occupancy was traditionally high, with potentially quite a difficult mix of patients. There were only four single rooms. The unit was regarded as a temporary and less than satisfactory environment. Given the high occupancy levels, **the panel considered** that it was unlikely that staff would have much time to engage in therapeutic work with patients.

4.25 The ward operated a key worker system, with a named nurse. Qualified staff would act as keyworker to a group of patients, and their responsibility was for the care planning for their patients, making sure the care plan was implemented and doing the evaluations. They would liase with other professionals in the community and communicate with the rest of the ward team.

It was unlikely that the key worker could always be available for the ward rounds, and if they were not available, a system operated to allocate someone to do the ward round each week, and key workers could then communicate with that person about anything which needed to be said about their patient.

4.26 At the time when DG was a patient on the ward, there was no system of clinical supervision in place. Individual members of staff had their own systems in place, if they wished to do so.

4.27 Staff on the ward would have access to the Child Protection Nurse, who was community based, and the Child Protection Doctor, who was a paediatrician.

Calderdale Social Services Department

4.28 The geographical area covered by Calderdale Social Services is large but not densely populated outside Halifax and the townships.

4.29 It was evident to the panel that the period from the mid nineteen nineties had been one of frequent change for the Social Services Department in Calderdale. One director took early retirement in 1996, and there was a period with an acting director, before a new director took up post in early 1997.

4.30 The new director sought to dismantle an existing system of purchaser/provider split, which was a quite protracted procedure. It took time to establish what the new shape of the department should be and at what level posts should be created. This created a degree of uncertainty, with posts unfilled at managerial level, although the service remained stable at fieldwork level.

4.31 Service provision at that time was organised into Children's Services, Mental Health and Learning Difficulties Service, and Adult Services. Relationships with Health services at officer level were excellent, and a Joint Services Planning Group met monthly. For a number of reasons, however, the Community Mental Health Teams still had a structure with both a Social Services Manager and a Health Service Manager, which has been discussed earlier. Some of the difficulty in moving forward from this position was caused by the number of changes which were taking place in the Health Service, which created a reluctance to make any changes until the Health Service reorganisation was complete.

4.32 Calderdale Social Services Department had lead responsibility for the child protection work in the area. Policy and Procedure manuals were issued in 1993 and an undated later version, which is the one likely to have been in force at the time of the incident involving DG and MG.

In that version, physical abuse is defined as including actual or likely physical injury to a child. Under section 47 of the Children Act 1989, a local authority is under a duty to investigate the circumstances of a child at risk, where the local authority has reasonable cause to suspect that the child is suffering or is likely to suffer significant harm. The procedure sets out at section 12 that all staff of the Social Services Department have a duty to be familiar with and to operate the procedures.

4.33 The procedures suggest that an initial case conference should be held on new cases where the agency determines that significant harm has occurred or is likely to occur to the child, and it is in the child's interests. The procedure also suggests that in cases where there is considerable doubt whether the identified harm is significant or not, it will normally be best to convene a conference in order to obtain the judgement of other agencies in that multi-disciplinary forum. The panel accepts that at the time when a social worker was involved in a meeting with DG's wife and the CPN from the Community Mental Health Team, it could be argued that there was no significant current risk to MG, as DG was an in-patient in the hospital. However, as he was a voluntary patient, and could have discharged himself at any time, the panel is of the view that in the spirit of the Child Protection procedures, an initial case conference should have been convened at that time. This would have permitted consideration of the need to enter MG on the Child Protection Register, especially as it may have elicited the information that DG was going out from the hospital even before formal leave plans had been made, and that his behaviour at home on at least one of these occasions had given rise to serious anxiety when he had searched through the house for razor blades.

4.34 In section 14 of the Child Protection procedures, which relates to Health Service staff, it is made clear that all health service staff, even if the majority of their work is not with children, must be aware of and abide by the agreed Child Protection procedures. The procedures recognise that the health service professional may not be providing care directly to the child, but nevertheless, the health care worker should not presume that other staff are taking the necessary action to ensure the safety of the child. In this case, the panel accepts that the CPN did inform Social Services.

4.35 Section 14 also indicates that the level of training in child protection for health service staff will depend on the type of work undertaken and the level of responsibility, but all health service staff should have basic training in child protection issues, have access to child protection procedures, and have a senior colleague with whom they can discuss concerns about child protection issues. The panel has noted with concern earlier in this report that none of the key staff on the ward or in the Community Mental Health Team consulted the Child Protection Doctor or Nurse in connection with DG and MG.

CHAPTER FIVE

Key Findings and Conclusions of the Panel

5. Throughout this report, the panel has sought to comment on matters as they have been raised in the narrative. These comments are highlighted in bold in the text of earlier chapters. We now list our key findings.

5.1 The threats made by DG to commit suicide and to take MG, his son, with him were documented in a variety of records and could have been known to all of those in health and social services who were caring for him.

5.2 The care afforded to DG by his GP practice was appropriate, timely and satisfactory.

5.3 The pain suffered by DG in respect of his back was as a result of physical causes, with a psychosomatic overlay.

5.4 The in-patient ward at Northowram Hospital was not a therapeutic environment for DG.

5.5 There was inadequate liaison and co-ordination between the in-patient ward at Northowram Hospital and Social Services regarding child protection issues in relation to periods of leave for DGand his ultimate discharge.

5.6 After his in-patient stay at Northowram Hospital in August and September 1998, DG's mental health did significantly improve for a period, up to February 1999.

5.7 From March 1999, the preoccupation of health staff with DG's physical problems caused key signs relevant to his mental health to be overlooked or minimised in significance.

5.8 The existence of a child protection issue was not afforded sufficient significance and status by the Community Mental Health Team, and they did not involve the Child Protection doctor or nurse.

5.9 The existence of a child protection issue was not properly taken up by the social workers involved in this case.

5.10 The Community Mental Health Team and the social workers did not give sufficient attention to the overall family and carer perspective in this case.

5.11 No multi-agency meeting was ever convened in respect of the well documented risk posed by DG to himself and to MG.

5.12 Throughout the period of DG's care in relation to his mental health problems, there were inadequate and infrequent formal written assessments of risk, and the one that was undertaken was not appropriately communicated and shared.

5.13 In social services, there were inadequate arrangements for monitoring and oversight of cases that were being transferred.

5.14 In social services, there was inadequate management oversight, review and follow up from prompts contained in Detail Records.

5.15 Arrangements for professional supervision in relation to members of the Community Mental Health Team, nurses on the in-patient ward, and social workers were not adequate.

5.16 Joint training of health and social workers in key aspects such as child protection did not routinely occur.

5.17 The standard of record keeping in health and social services fell short of acceptable practice in some instances.

5.18 There is a lack of evidence that care planning formed an integral part of the health process.

5.19 There has been no substantive consultant psychiatrist appointment in post at Northowram Hospital and its successor service from July 1995.

5.20 Over the period under review there has been significant change and restructuring in both health and social services, but more so in social services.

Conclusions of the panel

Based on the findings, the panel has concluded that at the time when DG was receiving care and treatment, there were shortcomings in both Health and Social Services in how they functioned and inter-related.

However, while we have found clear examples of failings, both in systems and in the personal practice of some staff in the care and treatment of DG, it is not possible to assert that the incidents at the heart of this review would have been prevented if these failings had not occurred.

The panel has concluded, however, that more information about the risk posed by DG, especially in relation to MG, would have helped DG's wife when she was faced with decisions whether she wished DG to be readmitted to hospital.

The panel has also concluded that if the services promised by Social Services had been forthcoming promptly, and had been supported by effective follow up, this could have reduced the stress being suffered by both DG and his wife, which in turn may have reduced the risk to MG.

The panel has concluded that during the period in question, there were insufficient checks and balances operating in Social Services.

CHAPTER SIX

Recommendations of the Panel

6. The panel recognises that significant reorganisation has occurred in both Health and Social Services since the incident which is the subject of this report. With these organisational changes in mind, the panel believes that it will be necessary for the current service providers to co-ordinate action on these recommendations, and to co-operate in their implementation. The first recommendation of the panel aims to assist such co-ordination and co-operation.

Recommendations

6.1 The panel recommends that each appropriate department in Health and Social Services affected by these recommendations should appoint a named individual with responsibility to co-ordinate the action planning and delivery of the recommendations.

6.2 The panel recommends that, in conjunction with the commissioners of the service, the Trust with operational responsibility for the in-patient ward should review the appropriateness of the patient mix being cared for on the ward.

6.3 The panel recommends that in conjunction with the commissioners of the service, the Trust should review the key nurse system, and support it with appropriate training.

6.4 The panel recommends that the Trust should ensure that individual performance appraisal is taking place, and that the IPR system used is robust, and that it permits staff to register their individual needs for training and support.

6.5 The panel recommends that the overall in-patient experience, including admission arrangements, assessment, treatment and discharge, be looked at with a view to improving processes, documentation, intervention, feedback, discharge planning and discharge.

6.6 The panel recommends that the Trust should review its position with regard to clinical supervision and monitor compliance with its policies and systems.

6.7 The panel recommends that the relevant Health and Social Services should develop joint training opportunities where appropriate, in particular in relations to inter-agency communication, Child Protection and risk assessment.

6.8 The panel recommends that the Trust and the commissioners of service consider the recruitment of substantive consultant cover.

6.9 The panel recommends that all relevant services review the need for training in effective record keeping, and the necessary audit mechanisms to ensure that standards set are maintained.

6.10 The panel recommends that all relevant services consider the need for training on multi-disciplinary and multi-agency team working.

6.11 The panel recommends that all relevant agencies should monitor compliance with CPA procedures and the procedures for risk assessment.

6.12 The panel recommends that agencies should take every opportunity to re-emphasize with their staff the need to involve carers effectively in the care process, and to ensure where appropriate that carers are made aware of levels of risk.

6.13 The panel recommends that agencies should take opportunities to re-emphasize with staff the importance of effective liaison between all relevant agencies in relation to care plans, home leave and discharge plans.

6.14 The panel recommends that all relevant staff within the Health Service are made fully aware of the role of the Child Protection Doctor and Nurse, and the means by which they can be contacted.

6.15 The panel recommends that appropriate steps are taken to ensure that all staff have mandatory Child Protection Training. This training should cover staff on the in-patient ward, as well as Community Mental Health Team staff and their managers.

6.16 The panel recommends that there should be a review of the Child Protection Procedures to emphasize potential risk to children in households where a carer is mentally ill.

6.17 The panel recommends that Social Services should review its duty system, its system of review of duty reports by team leaders and senior staff and its case allocation system.

6.18 The panel recommends that Social Services should have effective systems in place for the case transfer process, to ensure that oversight of cases is not lost during this process.

6.19 The panel recommends that social workers working in the fields of child and family care should have awareness of mental health issues.

6.20 The panel recommends that Social Services should ensure that effective transitional arrangements are in place when organisational change is occurring.

Appendix A

PROCEDURE ADOPTED BY THE INQUIRY

The panel adopted a procedure based on study of previous independent inquiries, the detail of which is as follows:

1. The panel sought the consent of the widow of DG for the disclosure of all appropriate records.

2. The panel studied the clinical and social work notes for DG and also the social services records of MG. The panel also studied local and national policies and procedures. From these sources, persons were identified whom the panel believed may have useful information to contribute to the Inquiry.

3. The chairman of the panel arranged to meet close relatives of DG, to inform them of the processes to be followed, and to answer any questions they may have about the Inquiry.

4. In a letter inviting people to attend the oral hearings, witnesses were informed that they could be accompanied by a friend, relative, member of a trade union, solicitor or anyone else; that it was the witness to whom questions would be addressed and who would be expected to respond; that witnesses could raise any matters which they felt might be relevant to the inquiry; that they would receive a transcript of their interview.

5. Sittings of the inquiry Panel took place in private.

6. Those attending the oral hearings were informed that if the draft report contained any points of potential criticism about any individual, that these would be put to them, giving them a full opportunity to respond. Any response would be considered by the panel, with a view to making any appropriate amendments or corrections to the draft report.

7. Those attending the oral hearings were informed that the recommendations of the Inquiry would be made public.

Appendix B

FULL INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF DG

TERMS OF REFERENCE

1. To examine all the circumstances surrounding the care and treatment of DG by mental health services in Calderdale (Calderdale NHS Trust and Calderdale Social Services), in particular:
   - the quality and scope of the health and social care
   - the assessment of management of risk
   - the appropriateness of the treatment, care and supervision in respect of:

   - his assessed health and social care needs
   - his risk assessment (in terms of the risk to harm himself and/or others)
   - any previous psychiatric history, including drug, substance or alcohol abuse
   - the nature of any previous involvement with the criminal justice system, including outcomes

   - the appropriateness of the professional and in-service training of those involved in the care of DG, or in the provision of service to him

   - The extent to which statutory obligations were met in care plans (including Care Programme Approach (HC(90)23/LASSL(90)11, and subsequent updates of this legislation, Supervision Registers HSG(94)5, and any subsequent updates of this legislation, and discharge guidance provided in HSG(94)27

   - The extent to which local policies were adhered to in the care planning process

   - The extent to which the care plan:
     - addressed his needs
     - was effectively drawn-up
     - was effectively delivered
     - was complied with by DG

   - the details of any medication, including retrospective information and compliance issues

2. To examine the adequacy of collaboration and communication between:

   - the agencies involved in the care and treatment of DG
   - the agencies involved in the care and treatment of his son MG
   - the agencies above, DG, and his family, advocates

3. To examine the Part 8 Review Report on the care and treatment of his son MG and identify issues relevant to this enquiry

4. To prepare a report for Calderdale and Kirklees Health Authority and make recommendations for all agencies involved where policy or practice issues need to be addressed

5. To publish those recommendations

Appendix C

12 December 2001
Strictly Personal and Confidential

Dear

Independent Inquiry into the care and treatment of DG

Calderdale and Kirklees Health Authority has set up this inquiry as required by Health Service Guideline HSG (94) 27 after discussion with the NHS Executive Regional Office. The HSG requires the Health Authority to hold an Independent Inquiry in the case of a homicide committed by a mentally ill person. DG who was under the care of the mental health services took his own life after unlawfully taking the life of his son MG on the 20th July 1999.

The panel set up to conduct the inquiry consists of Dr David Armstrong a consultant psychiatrist from East Yorkshire, Ms Anne Butterworth a recently retired senior health service manager and registered Mental Nurse from Northumberland and Ms Margaret Errington , an approved Social Worker and a social work manager, and myself as Chairman of the panel. I am a retired academic lawyer from Northumberland and a former Chairman of the Royal Victoria Infirmary NHS Trust in Newcastle.

A copy of the terms of reference set for the inquiry is attached for your information, together with a copy of the authorisation signed by, the widow of DG, for the disclosure of the records relating to his care and treatment.
We consider that you can provide evidence to assist this independent inquiry and would therefore request you to attend a hearing on …………… at …………. If this date is not possible for you please discuss alternative dates to attend with the Inquiry Administrator. Your reasonable travelling expenses and subsistence costs arising from your attendance at the inquiry will be reimbursed. The hearing will be held at the offices of Calderdale and Kirklees Health Authority at the address shown above. (A map is attached for your information)

When giving your evidence you may be accompanied by a friend or relative, trade union representative, lawyer or anyone else with the exception of another inquiry witness. However, it is to you that questions will be directed and from whom replies will be sought. You may raise any matter you wish, which you believe is relevant to the inquiry. A transcript of your oral evidence will be made and a copy will be sent to you afterwards, which you will be asked to sign and return.

Please could you confirm your attendance by ringing the Inquiry Administrator.

I would like to thank you for your co-operation and assistance. If there is any matter in addition to the above on which I can give further explanation, please let me know.

I look forward to meeting you.

Yours sincerely

Anne Galbraith

Independent Inquiry Chairman

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